RECOGNIZING AND MANAGING EROTIC AND EROTICIZED TRANSFERENCES

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ABSTRACT

Transference has been proposed as a critical concept in psychotherapy. The transference may be positive, negative, or sexualized. When the transference becomes sexualized, there are potentially damaging outcomes depending on the management of the transference. This paper addresses the significance of early experiences in residency training with sexualized transference and focuses on the therapeutic relationship in which the transference has become eroticized. The author will explore the potential benefits and challenges of properly managing such transference.

INTRODUCTION

Transference has been described as unconscious feelings that are transposed onto another significant individual.[1] In the strictest sense, this occurs only in therapy settings, but in a more general sense it occurs throughout life. The experience of transference might be thought of as a means used by the brain to make sense of current experience by seeing the past in the present and limiting the input of new information.[2] Freud noticed the unusually and sometimes irrationally intense feelings that developed between patients and their analysts. He initially conceptualized the transference as the patient's attempt to repress

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childhood experiences. Later he observed that feelings of love not only occurred in the past outside the therapy session, but also during the analysis itself toward the analyst.[3]

Sexualized transference is any transference in which the patient's fantasies about the analyst contain elements that are primarily reverential, romantic, intimate, sensual, or sexual.[4] As early as 1915, Freud addressed this phenomenon in his paper, "Observation on Transference Love."[3] He described transference love as occurring when the patient openly announces love for the therapist.

At the time Freud wrote about "transference love," the field of psychoanalysis was under attack by the public. Some of these attacks centered on reports of sexual experiences between analysts and their patients. Freud struggled with whether transference came from the real relationship between the patient and therapist or if it was entirely unreal (i.e., displaced feelings from other relationships).

Today there are ongoing discussions in the literature about the nature and role of transference. The transference relationship is complex and multilayered while being significantly impacted by countertransferential reactions. The therapist has become less of a "blank screen" and more interactive with the patient and, therefore, a part of the developing transference. Transference may be utilized to gather psychological material and gain a deeper understanding of the patient's motivations.[5] Contemporary analysts contend, as their predecessors once did, that erotic transference reflects a patient's early life impulses and fantasies that emerge during the process of analysis.

TYPES OF TRANSFERENCE

In general, transference may manifest itself as positive, negative, or sexualized. In *positive transference,* the patient experiences enjoyable aspects of past relationships. Positive transferences are often helpful in therapy if the patient sees the therapist as wise, caring, and concerned.

Negative transference unleashes emotions that are painful or less desired. By discussing these negative emotions with the patient, the therapist hopes to help the patient achieve insight and to find ways to manage these feelings.

Positive and negative transference can become topics for discussion in therapy. The patient is encouraged to acknowledge and discuss emotional responses to the therapist, especially if they seem out of proportion to what has actually transpired in the session itself. This allows patients to make connections between what they are feeling in the room with their therapist and their early life experiences, and this enables development and growth.

Transference situations that are not interfering with the therapeutic process are often left uninterpreted. It can be a technical challenge to address transference in therapy, because raising awareness to the transference can stress the patient, leading to regression or awkward and embarrassing moments in therapy. The acknowledgment of transference feelings, if sexual, may be mistaken as an invitation for further flirtation or a sexual relationship. This could lead to the collapse of the safe environment the therapist has struggled to create.[6] It is of course unethical to use the discussion of the intense feelings involved in the transference for a therapist's own self-gratification, and this is to be avoided.

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COUNTERTRANSFERENCE: BOUNDARY ISSUES FOR PSYCHOTHERAPISTS

The intense emotional experience of countertransference in psychotherapy also is not rare. Some studies have reported that 95 percent of male therapists and 76 percent of female therapists admit that they felt sexual feelings toward their patients.[6] Identifying and therapeutically managing one's own intense feelings is one of the on-going challenges of psychodynamically based psychotherapy. These challenges are enhanced in the novice therapist who may have little training in these issues and virtually no experience with them.

PRACTICE POINT: Family of Origin Issues and Potential for Transference in the Therapeutic Relationship

Case example. *A middle-aged woman describes her childhood as being filled with rage. She attributes this to her emotionally abusive father and sexually abusive brother. She states that in order to enhance her sense of safety, she developed techniques to control and manipulate her father.*

In psychotherapy with a male therapist, a patient might display

behavior that is reminiscent of early childhood relationships. A female may become overtly flirtatious with her male therapist and inform her therapist that it would be more comfortable to have therapy at a local restaurant. In doing so, the patient unconsciously attempts to equalize the power differential by attempting to shift the frame under which the original therapy had been established. The therapist may view this as flattering or just a part of the patient's overall pathology. Nonetheless, being aware of the potential pitfalls of mismanaging the transference may be critical to helping the patient understand current and early childhood relationships.

THE CONCEPT OF TRANSFERENCE

Transference is a crucial component in the therapeutic relationship and should be incorporated into psychotherapy education from the beginning. During most psychiatric residencies, although transference is discussed in a general way, discussion on the management of sexualized transference often is limited.

Types of sexualized transference. The term *sexualized transference* is often used as the most general term and encompasses at least two more specific experiences, *erotic* and *eroticized* transference. Differentiating between the two types of sexualized transference is important because the intensity, the underlying motivation, and the appropriate interventions are different.

Erotic transference. The term *erotic transference* is generally reserved for positive transferences accompanied by sexual fantasies that the patient understands to be unrealistic.[7] This transference does not interfere with the patient's goal to gain insight and mature attachments.

Eroticized transference. Eroticized transference is an intense, vivid, irrational erotic preoccupation with the therapist characterized by overt, seemingly egosyntonic demands for love and sexual fulfillment.[1] The patient is unable to focus on developing appropriate insights and attends the sessions for the opportunity to be close to the therapist, with the hope that the therapist will reciprocate love.

> The appropriate response [by the therapist] to erotic transference often is to address the recent behavior in therapy without connecting it to early life experiences. This is because bringing behavior to conscious awareness without interpretation can help to minimize the risk of further "flirting" or other acting out.

PRACTICE POINT: The Therapist's Response to Sexualized Transference

Case example. *After several months of therapy, the patient begins to make flirtatious comments about the therapist's clothing and posture in the room.*

The therapist emphasizes, by words and actions, the boundaries of the psychotherapeutic relationship, while controlling any outward display of anxiety or discomfort. The purpose of this intervention is to create an environment where the patient feels comfortable spontaneously expressing feelings without being judged, shamed, or rejected, while still maintaining the structure and limits of the relationship.

In psychoanalytic terminology, Gabbard compares the relationship between the male "analyst" and female "analsyand" to that of father and adolescent daughter.[8] A father must remain sensitive and close to his daughter while maintaining the boundaries between them. For many psychiatric patients, early memories are plagued by episodes of intimidation and victimization by important adults, and boundaries may need to be reaffirmed frequently to prevent misinterpretations of activities and comments in therapy sessions.

Sexualized transference was acknowledged initially in Freud's early writings. Freud became aware of the phenomenon while working closely with the case of "Anna O," but at the time he was reluctant to acknowledge such transference. It was not until several cases later that he realized the significance of this transference. He thought it was important that analysts understand "transference love," so that they were able to appropriately manage it.

Unfortunately, sexualized transference is usually discussed in the context of a therapy case where the therapist presumably mismanaged the transference. Proper management of sexualized transference often can be therapeutic, however. The nature of transference is that it is unconscious and thus out of the patient's awareness. A skilled therapist can assist the patient to identify and work through the issues that are involved.[9]

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early life experiences. This is because bringing behavior to conscious awareness without interpretation can help to minimize the risk of further "flirting" or other acting out. When such an intervention is successful, psychotherapy becomes more beneficial. Often the patient feels less guarded and more open to gaining and utilizing insight, particularly with respect to intimate feelings and concerns about other important male figures in her life.

Making any connection between early childhood experiences and transference early in the therapeutic relationship might be inappropriate as there may not have been enough time to establish positive rapport. Such an interpretation may be rejected if it is prematurely offered. This is a delicate topic that requires well-developed rapport with the patient to limit the potential risk of the patient impulsively terminating therapy.

THE IMPORTANCE OF MAINTAINING APPROPRIATE BOUNDARIES

If the therapist experiences sexual feelings for a patient, the therapist may become either inappropriately involved with the patient or aloof toward the patient in an effort to maintain emotional distance.[7] Either of these responses can cause further injury to the patient. Novice therapists in particular may have trouble negotiating the boundary between distancing themselves from patients and becoming overly involved. The beginning therapist may be frightened of the patient's intense emotions and tend to ignore or overreact to them. Although the novice may have read about sexualized transference, he or she may be tempted to deny its power when working with a patient because of lack of confidence in one's ability to manage it or because he or she believes that others will see this identification of sexualized transference as clinically inaccurate or based on their own narcissism.[3] These issues should be carefully addressed in supervision or peer consultation if needed, so that therapy can progress while appropriate boundaries are carefully maintained and no serious boundary violations occur.

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